

AMENDED IN ASSEMBLY SEPTEMBER 6, 2013

AMENDED IN ASSEMBLY SEPTEMBER 3, 2013

AMENDED IN ASSEMBLY AUGUST 6, 2013

AMENDED IN SENATE MAY 28, 2013

AMENDED IN SENATE APRIL 9, 2013

AMENDED IN SENATE APRIL 1, 2013

SENATE BILL

No. 639

Introduced by Senator Hernandez

February 22, 2013

An act to amend ~~Section~~ *Sections 1357.503 and 1367 of, and to add Sections 1367.006, 1367.007, 1367.008, and 1367.009 to, and to add and repeal Section 1367.0065 of, the Health and Safety Code, and to amend Section 10753.05 of, and to add Sections 10112.28, 10112.29, 10112.295, 10112.297, and 10112.7 to, and to add and repeal Section 10112.285 of, the Insurance Code, relating to health care coverage.*

LEGISLATIVE COUNSEL'S DIGEST

SB 639, as amended, Hernandez. Health care coverage.

Existing federal law, the federal Patient Protection and Affordable Care Act (PPACA), enacts various health care coverage market reforms that take effect January 1, 2014. Among other things, PPACA establishes annual limits on deductibles for employer-sponsored plans and defines bronze, silver, gold, and platinum levels of coverage for the nongrandfathered individual and small group markets.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans

by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance.

This bill would prohibit the deductible under a small employer health care service plan contract or health insurance policy offered, sold, or renewed on or after January 1, 2014, from exceeding \$2,000 in the case of a plan contract or policy covering a single individual, or \$4,000 in all other cases. *That provision would not apply to multiple employer welfare arrangements, as specified.*

The bill would require, for nongrandfathered products in the individual or small group markets, a health care service plan contract or health insurance policy, except a specialized health insurance policy, that is issued, amended, or renewed on or after January 1, 2014, to provide for a limit on annual out-of-pocket expenses for all covered benefits that meet the definition of essential health benefits, as defined, and would require the contract or policy, for nongrandfathered products in the large group market, to provide that limit for covered benefits, including out-of-network emergency care, to the extent that the limit does not conflict with federal law or guidance, as specified. *The bill would set the limit at \$6,500 for individual coverage and \$12,700 for family coverage for the 2014 plan and policy years, and would set a specified limit for pediatric oral care benefits. For later years, those limits would be set using a specified provision of federal law.* The bill would prohibit the total annual out-of-pocket maximum for all covered essential benefits from exceeding that limit for a specialized plan or specialized health insurance policy that offers or provides an essential health benefit, as specified, in plan or policy years beginning on or after January 1, 2015.

~~The bill would provide that in the first plan year or policy year commencing on or after January 1, 2014, to the extent allowed by federal law, for nongrandfathered products in the individual and small group markets, when a plan or insurer uses a separate service provider to administer pediatric oral care benefits, the limit on annual out-of-pocket expenses would be satisfied if the plan or policy complies with a specified out-of-pocket maximum for all other essential health benefits and the separate out-of-pocket maximum for the pediatric oral care benefits does not exceed the out-of-pocket maximum requirements for pediatric dental benefits established for stand-alone dental plans by the California Health Benefit Exchange. The bill would also prohibit a plan~~

or insurer from applying a separate out-of-pocket maximum to mental health or substance use disorder benefits.

The bill would define bronze, silver, gold, and platinum levels of coverage for the nongrandfathered individual and small group markets consistent with the definitions in PPACA. The bill would prohibit a carrier that is not participating in the Exchange from offering a catastrophic plan, as defined, in the individual market.

PPACA requires a health insurance issuer offering group or individual coverage that provides or covers benefits with respect to services in the emergency department of a hospital to cover emergency services without the need for prior authorization, regardless of whether the provider is a participating provider, and subject to the same cost sharing required if the services were provided by a participating provider, as specified.

This bill would impose that requirement with respect to health insurance policies issued, amended, or renewed on or after January 1, 2014, as specified.

Existing law requires a health care service plan and carrier providing coverage to small employers each calendar year to establish an index rate for the small employer market in the state based on the total combined claims costs for providing essential health benefits within a single risk pool, as specified.

This bill would require that index rate to be established at least each calendar year and no more frequently than each calendar quarter.

Because a willful violation of these requirements with respect to health care service plans would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: yes.

The people of the State of California do enact as follows:

- 1 SECTION 1. Section 1357.503 of the Health and Safety Code,
- 2 as amended by Chapter 2 of the First Extraordinary Session of
- 3 the Statutes of 2013, is amended to read:

1 1357.503. (a) (1) On and after October 1, 2013, a plan shall
2 fairly and affirmatively offer, market, and sell all of the plan's
3 small employer health care service plan contracts for plan years
4 on or after January 1, 2014, to all small employers in each service
5 area in which the plan provides or arranges for the provision of
6 health care services.

7 (2) On and after October 1, 2013, a plan shall make available
8 to each small employer all small employer health care service plan
9 contracts that the plan offers and sells to small employers or to
10 associations that include small employers in this state for plan
11 years on or after January 1, 2014. Health coverage through an
12 association that is not related to employment shall be considered
13 individual coverage pursuant to Section 144.102(c) of Title 45 of
14 the Code of Federal Regulations.

15 (3) A plan that offers qualified health plans through the
16 Exchange shall be deemed to be in compliance with paragraphs
17 (1) and (2) with respect to small employer health care service plan
18 contracts offered through the Exchange in those geographic regions
19 in which the plan offers plan contracts through the Exchange.

20 (b) A plan shall provide enrollment periods consistent with
21 PPACA and described in Section 155.725 of Title 45 of the Code
22 of Federal Regulations. Commencing January 1, 2014, a plan shall
23 provide special enrollment periods consistent with the special
24 enrollment periods described in Section 1399.849, to the extent
25 permitted by PPACA, except for the triggering events identified
26 in paragraphs (d)(3) and (d)(6) of Section 155.420 of Title 45 of
27 the Code of Federal Regulations with respect to plan contracts
28 offered through the Exchange.

29 (c) No plan or solicitor shall induce or otherwise encourage a
30 small employer to separate or otherwise exclude an eligible
31 employee from a health care service plan contract that is provided
32 in connection with employee's employment or membership in a
33 guaranteed association.

34 (d) Every plan shall file with the director the reasonable
35 employee participation requirements and employer contribution
36 requirements that will be applied in offering its plan contracts.
37 Participation requirements shall be applied uniformly among all
38 small employer groups, except that a plan may vary application
39 of minimum employee participation requirements by the size of
40 the small employer group and whether the employer contributes

1 100 percent of the eligible employee's premium. Employer
2 contribution requirements shall not vary by employer size. A health
3 care service plan shall not establish a participation requirement
4 that (1) requires a person who meets the definition of a dependent
5 in Section 1357.500 to enroll as a dependent if he or she is
6 otherwise eligible for coverage and wishes to enroll as an eligible
7 employee and (2) allows a plan to reject an otherwise eligible small
8 employer because of the number of persons that waive coverage
9 due to coverage through another employer. Members of an
10 association eligible for health coverage under subdivision (m) of
11 Section 1357.500, but not electing any health coverage through
12 the association, shall not be counted as eligible employees for
13 purposes of determining whether the guaranteed association meets
14 a plan's reasonable participation standards.

15 (e) The plan shall not reject an application from a small
16 employer for a small employer health care service plan contract
17 if all of the following conditions are met:

18 (1) The small employer offers health benefits to 100 percent of
19 its eligible employees. Employees who waive coverage on the
20 grounds that they have other group coverage shall not be counted
21 as eligible employees.

22 (2) The small employer agrees to make the required premium
23 payments.

24 (3) The small employer agrees to inform the small employer's
25 employees of the availability of coverage and the provision that
26 those not electing coverage must wait until the next open
27 enrollment or a special enrollment period to obtain coverage
28 through the group if they later decide they would like to have
29 coverage.

30 (4) The employees and their dependents who are to be covered
31 by the plan contract work or reside in the service area in which
32 the plan provides or otherwise arranges for the provision of health
33 care services.

34 (f) No plan or solicitor shall, directly or indirectly, engage in
35 the following activities:

36 (1) Encourage or direct small employers to refrain from filing
37 an application for coverage with a plan because of the health status,
38 claims experience, industry, occupation of the small employer, or
39 geographic location provided that it is within the plan's approved
40 service area.

(2) Encourage or direct small employers to seek coverage from another plan because of the health status, claims experience, industry, occupation of the small employer, or geographic location provided that it is within the plan's approved service area.

(3) Employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs or discriminate based on an individual's race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life, or other health conditions.

(g) A plan shall not, directly or indirectly, enter into any contract, agreement, or arrangement with a solicitor that provides for or results in the compensation paid to a solicitor for the sale of a health care service plan contract to be varied because of the health status, claims experience, industry, occupation, or geographic location of the small employer. This subdivision does not apply to a compensation arrangement that provides compensation to a solicitor on the basis of percentage of premium, provided that the percentage shall not vary because of the health status, claims experience, industry, occupation, or geographic area of the small employer.

(h) (1) A policy or contract that covers a small employer, as defined in Section 1304(b) of PPACA and in Section 1357.500, shall not establish rules for eligibility, including continued eligibility, of an individual, or dependent of an individual, to enroll under the terms of the policy or contract based on any of the following health status-related factors:

- (A) Health status.
- (B) Medical condition, including physical and mental illnesses.
- (C) Claims experience.
- (D) Receipt of health care.
- (E) Medical history.
- (F) Genetic information.
- (G) Evidence of insurability, including conditions arising out of acts of domestic violence.
- (H) Disability.
- (I) Any other health status-related factor as determined by any federal regulations, rules, or guidance issued pursuant to Section 2705 of the federal Public Health Service Act.

(2) Notwithstanding Section 1389.1, a health care service plan shall not require an eligible employee or dependent to fill out a health assessment or medical questionnaire prior to enrollment under a small employer health care service plan contract. A health care service plan shall not acquire or request information that relates to a health status-related factor from the applicant or his or her dependent or any other source prior to enrollment of the individual.

(i) (1) A health care service plan shall consider as a single risk pool for rating purposes in the small employer market the claims experience of all enrollees in all nongrandfathered small employer health benefit plans offered by the health care service plan in this state, whether offered as health care service plan contracts or health insurance policies, including those insureds and enrollees who enroll in coverage through the Exchange and insureds and enrollees covered by the health care service plan outside of the Exchange.

~~Each~~ *At least each calendar year, and no more frequently than each calendar quarter,* a health care service plan shall establish an index rate for the small employer market in the state based on the total combined claims costs for providing essential health benefits, as defined pursuant to Section 1302 of PPACA and Section 1367.005, within the single risk pool required under paragraph (1). The index rate shall be adjusted on a marketwide basis based on the total expected marketwide payments and charges under the risk adjustment and reinsurance programs established for the state pursuant to Sections 1343 and 1341 of PPACA. The premium rate for all of the health care service plan's nongrandfathered small employer health care service plan contracts shall use the applicable index rate, as adjusted for total expected marketwide payments and charges under the risk adjustment and reinsurance programs established for the state pursuant to Sections 1343 and 1341 of PPACA, subject only to the adjustments permitted under paragraph (3).

(3) A health care service plan may vary premium rates for a particular nongrandfathered small employer health care service plan contract from its index rate based only on the following actuarially justified plan-specific factors:

(A) The actuarial value and cost-sharing design of the plan contract.

1 (B) The plan contract's provider network, delivery system
2 characteristics, and utilization management practices.

3 (C) The benefits provided under the plan contract that are in
4 addition to the essential health benefits, as defined pursuant to
5 Section 1302 of PPACA. These additional benefits shall be pooled
6 with similar benefits within the single risk pool required under
7 paragraph (1) and the claims experience from those benefits shall
8 be utilized to determine rate variations for plan contracts that offer
9 those benefits in addition to essential health benefits.

10 (D) With respect to catastrophic plans, as described in subsection
11 (e) of Section 1302 of PPACA, the expected impact of the specific
12 eligibility categories for those plans.

13 (E) Administrative costs, excluding any user fees required by
14 the Exchange.

15 (j) A plan shall comply with the requirements of Section 1374.3.

16 (k) (1) Except as provided in paragraph (2), if Section 2702 of
17 the federal Public Health Service Act (42 U.S.C. Sec. 300gg-1),
18 as added by Section 1201 of PPACA, is repealed, this section shall
19 become inoperative 12 months after the repeal date, in which case
20 health care service plans subject to this section shall instead be
21 governed by Section 1357.03 to the extent permitted by federal
22 law, and all references in this article to this section shall instead
23 refer to Section 1357.03 except for purposes of paragraph (2).

24 (2) Subdivision (b) shall remain operative with respect to health
25 care service plan contracts offered through the Exchange.

26 **SECTION 1.**

27 *SEC. 2.* Section 1367 of the Health and Safety Code is amended
28 to read:

29 1367. A health care service plan and, if applicable, a specialized
30 health care service plan shall meet the following requirements:

31 (a) Facilities located in this state including, but not limited to,
32 clinics, hospitals, and skilled nursing facilities to be utilized by
33 the plan shall be licensed by the State Department of Public Health,
34 where licensure is required by law. Facilities not located in this
35 state shall conform to all licensing and other requirements of the
36 jurisdiction in which they are located.

37 (b) Personnel employed by or under contract to the plan shall
38 be licensed or certified by their respective board or agency, where
39 licensure or certification is required by law.

1 (c) Equipment required to be licensed or registered by law shall
2 be so licensed or registered, and the operating personnel for that
3 equipment shall be licensed or certified as required by law.

4 (d) The plan shall furnish services in a manner providing
5 continuity of care and ready referral of patients to other providers
6 at times as may be appropriate consistent with good professional
7 practice.

8 (e) (1) All services shall be readily available at reasonable times
9 to each enrollee consistent with good professional practice. To the
10 extent feasible, the plan shall make all services readily accessible
11 to all enrollees consistent with Section 1367.03.

12 (2) To the extent that telehealth services are appropriately
13 provided through telehealth, as defined in subdivision (a) of Section
14 2290.5 of the Business and Professions Code, these services shall
15 be considered in determining compliance with Section 1300.67.2
16 of Title 28 of the California Code of Regulations.

17 (3) The plan shall make all services accessible and appropriate
18 consistent with Section 1367.04.

19 (f) The plan shall employ and utilize allied health manpower
20 for the furnishing of services to the extent permitted by law and
21 consistent with good medical practice.

22 (g) The plan shall have the organizational and administrative
23 capacity to provide services to subscribers and enrollees. The plan
24 shall be able to demonstrate to the department that medical
25 decisions are rendered by qualified medical providers, unhindered
26 by fiscal and administrative management.

27 (h) (1) Contracts with subscribers and enrollees, including
28 group contracts, and contracts with providers, and other persons
29 furnishing services, equipment, or facilities to or in connection
30 with the plan, shall be fair, reasonable, and consistent with the
31 objectives of this chapter. All contracts with providers shall contain
32 provisions requiring a fast, fair, and cost-effective dispute
33 resolution mechanism under which providers may submit disputes
34 to the plan, and requiring the plan to inform its providers upon
35 contracting with the plan, or upon change to these provisions, of
36 the procedures for processing and resolving disputes, including
37 the location and telephone number where information regarding
38 disputes may be submitted.

1 (2) A health care service plan shall ensure that a dispute
2 resolution mechanism is accessible to noncontracting providers
3 for the purpose of resolving billing and claims disputes.

4 (3) On and after January 1, 2002, a health care service plan shall
5 annually submit a report to the department regarding its dispute
6 resolution mechanism. The report shall include information on the
7 number of providers who utilized the dispute resolution mechanism
8 and a summary of the disposition of those disputes.

9 (i) A health care service plan contract shall provide to
10 subscribers and enrollees all of the basic health care services
11 included in subdivision (b) of Section 1345, except that the director
12 may, for good cause, by rule or order exempt a plan contract or
13 any class of plan contracts from that requirement. The director
14 shall by rule define the scope of each basic health care service that
15 health care service plans are required to provide as a minimum for
16 licensure under this chapter. Nothing in this chapter shall prohibit
17 a health care service plan from charging subscribers or enrollees
18 a copayment or a deductible for a basic health care service
19 consistent with Section 1367.006 or 1367.007, provided that the
20 copayments, deductibles, or other cost sharing are reported to the
21 director and set forth to the subscriber or enrollee pursuant to the
22 disclosure provisions of Section 1363. Nothing in this chapter shall
23 prohibit a health care service plan from setting forth, by contract,
24 limitations on maximum coverage of basic health care services,
25 provided that the limitations are reported to, and held
26 unobjectionable by, the director and set forth to the subscriber or
27 enrollee pursuant to the disclosure provisions of Section 1363.

28 (j) A health care service plan shall not require registration under
29 the federal Controlled Substances Act (21 U.S.C. Sec. 801 et seq.)
30 as a condition for participation by an optometrist certified to use
31 therapeutic pharmaceutical agents pursuant to Section 3041.3 of
32 the Business and Professions Code.

33 Nothing in this section shall be construed to permit the director
34 to establish the rates charged subscribers and enrollees for
35 contractual health care services.

36 The director's enforcement of Article 3.1 (commencing with
37 Section 1357) shall not be deemed to establish the rates charged
38 subscribers and enrollees for contractual health care services.

39 The obligation of the plan to comply with this chapter shall not
40 be waived when the plan delegates any services that it is required

1 to perform to its medical groups, independent practice associations,
2 or other contracting entities.

3 ~~SEC. 2.~~

4 *SEC. 3.* Section 1367.006 is added to the Health and Safety
5 Code, to read:

6 1367.006. (a) *This section shall apply to nongrandfathered*
7 *individual and group health care service plan contracts that*
8 *provide coverage for essential health benefits, as defined in Section*
9 *1367.005, and that are issued, amended, or renewed on or after*
10 *January 1, 2015.*

11 (b) (1) For nongrandfathered ~~products~~ *health care service plan*
12 *contracts* in the individual or small group markets, a health care
13 service plan contract, except a specialized health care service plan
14 contract, that is issued, amended, or renewed on or after January
15 1, ~~2014,~~ 2015, shall provide for a limit on annual out-of-pocket
16 expenses for all covered benefits that meet the definition of
17 essential health benefits in Section 1367.005, *including*
18 *out-of-network emergency care consistent with Section 1317.4.*

19 ~~(A) In the first plan year commencing on or after January 1,~~
20 ~~2014, to the extent allowed by federal law, for nongrandfathered~~
21 ~~products in the individual and small group markets, when a health~~
22 ~~care service plan uses a separate service provider to administer the~~
23 ~~pediatric oral care benefits required by Section 1367.005, the limit~~
24 ~~on annual out-of-pocket expenses shall be satisfied if both of the~~
25 ~~following conditions are met:~~

26 (i) ~~With respect to all essential health benefits except for the~~
27 ~~pediatric oral care benefit, the health care service plan complies~~
28 ~~with the out-of-pocket maximum requirements in Section~~
29 ~~1302(e)(1) of PPACA and any federal rules, regulations, and~~
30 ~~guidance implementing that section.~~

31 (ii) ~~The separate out-of-pocket maximum for pediatric oral care~~
32 ~~benefits does not exceed the out-of-pocket maximum requirements~~
33 ~~for pediatric dental benefits established for stand-alone dental plans~~
34 ~~by the California Health Benefit Exchange.~~

35 ~~(B) The health care service plan shall not apply a separate~~
36 ~~out-of-pocket maximum to mental health or substance use disorder~~
37 ~~benefits.~~

38 (2) For nongrandfathered ~~products~~ *health care service plan*
39 *contracts* in the large group market, a health care service plan
40 contract, except a specialized health care service plan contract,

1 that is issued, amended, or renewed on or after January 1, ~~2014,~~
2 ~~2015~~, shall provide for a limit on annual out-of-pocket expenses
3 for covered benefits, including out-of-network emergency care
4 consistent with Section 1371.4. This limit shall *only* apply to
5 essential health benefits, as defined in Section 1367.005, that are
6 covered under the plan to the extent that this provision does not
7 conflict with federal law or guidance on out-of-pocket maximums
8 for nongrandfathered ~~products~~ *health care service plan contracts*
9 in the large group market. ~~For large group products for the first~~
10 ~~plan year commencing on or after January 1, 2014, the requirement~~
11 ~~that a product provide for a limit on annual out-of-pocket expenses~~
12 ~~shall be satisfied if both of the following apply:~~

13 ~~(A) The product complies with the requirements of this~~
14 ~~paragraph with respect to basic health care services, as defined in~~
15 ~~subdivision (b) of Section 1345, services required under Sections~~
16 ~~1374.72 and 1374.73, and any requirements of the Paul Wellstone~~
17 ~~and Pete Domenici Mental Health Parity and Addiction Equity Act~~
18 ~~of 2008 (Public Law 110-343).~~

19 ~~(B) To the extent the product includes an out-of-pocket~~
20 ~~maximum on coverage other than the coverage described in~~
21 ~~subparagraph (A), that out-of-pocket maximum also does not~~
22 ~~exceed the limit established pursuant to this paragraph.~~

23 ~~(b) The limit described in subdivision (a) shall apply to any~~
24 ~~copayment, coinsurance, deductible, incentive payment, and any~~
25 ~~other form of cost sharing for all covered benefits, including~~
26 ~~prescription drugs covered pursuant to Section 1367.24.~~

27 ~~(c) (1) The limit described in subdivision (a) (b) shall not exceed~~
28 ~~the limit described in Section 1302(c) of PPACA, and any~~
29 ~~subsequent rules, regulations, or guidance issued under that section.~~

30 ~~(2) The limit described in subdivision (b) shall result in a total~~
31 ~~maximum out-of-pocket limit for all essential health benefits equal~~
32 ~~to the dollar amounts in effect under Section 223(c)(2)(A)(ii) of~~
33 ~~the Internal Revenue Code of 1986 with the dollar amounts~~
34 ~~adjusted as specified in Section 1302(c)(1)(B) of PPACA.~~

35 ~~(d) Nothing in this section shall be construed to affect the~~
36 ~~reduction in cost sharing for eligible enrollees described in Section~~
37 ~~1402 of PPACA, and any subsequent rules, regulations, or guidance~~
38 ~~issued under that section.~~

39 ~~(e) For plan years beginning on or after January 1, 2015, if~~
40 ~~an essential health benefit is offered or provided by a specialized~~

1 *health care service plan, the total annual out-of-pocket maximum*
2 *for all covered essential benefits shall not exceed the limit in this*
3 *section subdivision (b). This section shall not apply to a specialized*
4 *health care service plan that does not offer an essential health*
5 *benefit as defined in Section 1367.005.*

6 *(f) The maximum out-of-pocket limit shall apply to any*
7 *copayment, coinsurance, deductible, and any other form of cost*
8 *sharing for all covered benefits that meet the definition of essential*
9 *health benefits in Section 1367.005.*

10 ~~(f)~~
11 *(g) For nongrandfathered health plan contracts in the group*
12 *market, “plan year” has the meaning set forth in Section 144.103*
13 *of Title 45 of the Code of Federal Regulations. For*
14 *nongrandfathered health plan contracts sold in the individual*
15 *market, “plan year” means the calendar year.*

16 ~~(g)~~
17 *(h) “PPACA” means the federal Patient Protection and*
18 *Affordable Care Act (Public Law 111-148), as amended by the*
19 *federal Health Care and Education Reconciliation Act of 2010*
20 *(Public Law 111-152), and any rules, regulations, or guidance*
21 *issued thereunder.*

22 *SEC. 4. Section 1367.0065 is added to the Health and Safety*
23 *Code, to read:*

24 *1367.0065. (a) This section shall apply to nongrandfathered*
25 *individual and group health care service plan contracts that*
26 *provide coverage for essential health benefits defined in Section*
27 *1367.005 and that are issued, amended, or renewed for the 2014*
28 *plan year.*

29 *(b) (1) For nongrandfathered health care service plan contracts*
30 *in the individual market, and to the extent allowed by federal law,*
31 *regulations, and guidance, a health care service plan contract,*
32 *except a specialized health care service plan contract, shall provide*
33 *for a limit on annual out-of-pocket expenses for all covered benefits*
34 *that meet the definition of essential health benefits as defined in*
35 *Section 1367.005, including out-of-network emergency care*
36 *consistent with Section 1371.4. The total out-of-pocket maximum*
37 *shall not exceed six thousand three hundred fifty dollars (\$6,350)*
38 *for individual coverage and twelve thousand seven hundred dollars*
39 *(\$12,700) for family coverage.*

(2) For nongrandfathered specialized health care service plan contracts in the individual market that provide the pediatric oral care benefit meeting the definition in Section 1302(b)(1)(j) of PPACA, the out-of-pocket maximum for the pediatric oral care benefit shall not exceed one thousand dollars (\$1,000) for one child and two thousand dollars (\$2,000) for more than one child.

(3) A health care service plan shall not apply a separate out-of-pocket maximum to mental health or substance use disorder benefits.

(c) For nongrandfathered health care service plan contracts in the small group markets, and to the extent allowed by federal law, regulations, and guidance, a health care service plan contract, except a specialized health care service plan contract, shall provide for a limit on annual out-of-pocket expenses for all covered benefits that meet the definition of essential health benefits, as defined in Section 1367.005, including out-of-network emergency care consistent with Section 1371.4, as follows:

(1) With respect to all essential health benefits, except for the pediatric oral care benefit, the total out-of-pocket maximum shall not exceed six thousand three hundred fifty dollars (\$6,350) for individual coverage and twelve thousand seven hundred dollars (\$12,700) for family coverage. For small group health plan contracts the total out-of-pocket maximum limit in this paragraph may be split between prescription drug services and all other essential health benefits.

(2) The separate out-of-pocket maximum for pediatric oral care benefits meeting the definition in Section 1302(b)(1)(j) of PPACA shall not exceed one thousand dollars (\$1,000) for one child or two thousand dollars (\$2,000) for more than one child.

(3) A health care service plan shall not apply a separate out-of-pocket maximum to mental health or substance use disorder benefits.

(d) For nongrandfathered health care service plan contracts in the large group market, a health care service plan contract, except a specialized health care service plan contract, shall provide for a limit on annual out-of-pocket expenses for covered benefits, including out-of-network emergency care consistent with Section 1371.4. This limit shall apply only to essential health benefits, as defined in Section 1367.005, that are covered under the plan contract. This limit shall be as follows:

1 (1) *The total out-of-pocket maximum shall not exceed six*
2 *thousand three hundred fifty dollars (\$6,350) for individual*
3 *coverage or twelve thousand seven hundred dollars (\$12,700) for*
4 *family coverage with respect to basic health care services as*
5 *defined in subdivision (b) of Section 1345, and services, except*
6 *for prescription drugs, required under Sections 1374.72 and*
7 *1374.73.*

8 (2) *To the extent the plan contract includes an out-of-pocket*
9 *maximum on coverage other than the coverage defined in*
10 *paragraph (1), that out-of-pocket maximum shall not exceed six*
11 *thousand three hundred fifty dollars (\$6,350) for individual*
12 *coverage or twelve thousand seven hundred dollars (\$12,700) for*
13 *family coverage.*

14 (3) *An enrollee in a large group plan contract shall not be*
15 *subject to more than two limits on annual out-of-pocket expenses*
16 *for covered benefits that meet the definition of essential health*
17 *benefits.*

18 (4) *A health care service plan shall not apply a separate*
19 *out-of-pocket maximum to mental health or substance use disorder*
20 *benefits.*

21 (5) *This subdivision shall apply only to the extent that it does*
22 *not conflict with federal law or guidance on out-of-pocket*
23 *maximums for nongrandfathered health plan contracts in the large*
24 *group market.*

25 (e) *Nothing in this section shall be construed to affect the*
26 *reduction in cost sharing for eligible enrollees described in Section*
27 *1402 of PPACA, and any subsequent rules, regulations, or*
28 *guidance issued under that section.*

29 (f) *The limits described in this section shall apply to any*
30 *copayment, coinsurance, deductible, and any other form of cost*
31 *sharing for all covered services that meet the definition of essential*
32 *health benefits.*

33 (g) *For nongrandfathered health plan contracts in the group*
34 *market, “plan year” has the meaning set forth in Section 144.103*
35 *of Title 45 of the Code of Federal Regulations. For*
36 *nongrandfathered health plan contracts sold in the individual*
37 *market, “plan year” means the calendar year.*

38 (h) *“PPACA” means the federal Patient Protection and*
39 *Affordable Care Act (Public Law 111-148), as amended by the*
40 *federal Health Care and Education Reconciliation Act of 2010*

1 *(Public Law 111-152), and any rules, regulations, or guidance*
2 *issued thereunder.*

3 *(i) This section shall remain in effect only until January 1, 2016,*
4 *and as of that date is repealed, unless a later enacted statute, that*
5 *is enacted before January 1, 2016, deletes or extends that date.*

6 ~~SEC. 3.~~

7 SEC. 5. Section 1367.007 is added to the Health and Safety
8 Code, to read:

9 1367.007. (a) (1) For a small employer health care service
10 plan contract offered, sold, or renewed on or after January 1, 2014,
11 the deductible under the plan shall not exceed:

12 (A) Two thousand dollars (\$2,000) in the case of a plan contract
13 covering a single individual.

14 (B) Four thousand dollars (\$4,000) in the case of any other plan
15 contract.

16 (2) The dollar amounts in this section shall be indexed consistent
17 with Section 1302(c)(2) of PPACA and any federal rules or
18 guidance pursuant to that section.

19 (3) The limitation in this subdivision shall be applied in a
20 manner that does not affect the actuarial value of any small
21 employer health care service plan contract.

22 (4) For small group products at the bronze level of coverage,
23 as defined in Section 1367.008, the department may permit plans
24 to offer a higher deductible in order to meet the actuarial value
25 requirement of the bronze level. In making this determination, the
26 department shall consider affordability of cost sharing for enrollees
27 and shall also consider whether enrollees may be deterred from
28 seeking appropriate care because of higher cost sharing.

29 (b) Nothing in this section shall be construed to allow a plan
30 contract to have a deductible that applies to preventive services as
31 defined in Section 1367.002.

32 (c) "PPACA" means the federal Patient Protection and
33 Affordable Care Act (Public Law 111-148), as amended by the
34 federal Health Care and Education Reconciliation Act of 2010
35 (Public Law 111-152), and any rules, regulations, or guidance
36 issued thereunder.

37 ~~SEC. 4.~~

38 SEC. 6. Section 1367.008 is added to the Health and Safety
39 Code, to read:

1 1367.008. (a) Levels of coverage for the nongrandfathered
2 individual market are defined as follows:

3 (1) Bronze level: A health care service plan contract in the
4 bronze level shall provide a level of coverage that is actuarially
5 equivalent to 60 percent of the full actuarial value of the benefits
6 provided under the plan contract.

7 (2) Silver level: A health care service plan contract in the silver
8 level shall provide a level of coverage that is actuarially equivalent
9 to 70 percent of the full actuarial value of the benefits provided
10 under the plan contract.

11 (3) Gold level: A health care service plan contract in the gold
12 level shall provide a level of coverage that is actuarially equivalent
13 to 80 percent of the full actuarial value of the benefits provided
14 under the plan contract.

15 (4) Platinum level: A health care service plan contract in the
16 platinum level shall provide a level of coverage that is actuarially
17 equivalent to 90 percent of the full actuarial value of the benefits
18 provided under the plan contract.

19 (b) Actuarial value for nongrandfathered individual health care
20 service plan contracts shall be determined in accordance with the
21 following:

22 (1) Actuarial value shall not vary by more than plus or minus
23 2 percent.

24 (2) Actuarial value shall be determined on the basis of essential
25 health benefits as defined in Section 1367.005 and as provided to
26 a standard, nonelderly population. For this purpose, a standard
27 population shall not include those receiving coverage through the
28 Medi-Cal or Medicare programs.

29 (3) The department may use the actuarial value methodology
30 developed consistent with Section 1302(d) of PPACA.

31 (4) The actuarial value for pediatric dental benefits, whether
32 offered by a full service plan or a specialized plan, shall be
33 consistent with federal law and guidance applicable to the plan
34 type.

35 (5) The department, in consultation with the Department of
36 Insurance and the Exchange, shall consider whether to exercise
37 state-level flexibility with respect to the actuarial value calculator
38 in order to take into account the unique characteristics of the
39 California health care coverage market, including the prevalence
40 of health care service plans, total cost of care paid for by the plan,

1 price of care, patterns of service utilization, and relevant
2 demographic factors.

3 (c) (1) A catastrophic plan is a health care service plan contract
4 that provides no benefits for any plan year until the enrollee has
5 incurred cost-sharing expenses in an amount equal to the annual
6 limit on out-of-pocket costs as specified in Section 1367.006 except
7 that it shall provide coverage for at least three primary care visits.
8 A carrier that is not participating in the Exchange shall not offer,
9 market, or sell a catastrophic plan in the individual market.

10 (2) A catastrophic plan may be offered only in the individual
11 market and only if consistent with this paragraph. Catastrophic
12 plans may be offered only if either of the following apply:

13 (A) The individual purchasing the plan has not yet attained 30
14 years of age before the beginning of the plan year.

15 (B) The individual has a certificate of exemption from Section
16 5000(A) of the Internal Revenue Code because the individual is
17 not offered affordable coverage or because the individual faces
18 hardship.

19 (d) “PPACA” means the federal Patient Protection and
20 Affordable Care Act (Public Law 111-148), as amended by the
21 federal Health Care and Education Reconciliation Act of 2010
22 (Public Law 111-152), and any rules, regulations, or guidance
23 issued thereunder.

24 ~~SEC. 5.~~

25 *SEC. 7.* Section 1367.009 is added to the Health and Safety
26 Code, to read:

27 1367.009. (a) Levels of coverage for the nongrandfathered
28 small group market are defined as follows:

29 (1) Bronze level: A health care service plan contract in the
30 bronze level shall provide a level of coverage that is actuarially
31 equivalent to 60 percent of the full actuarial value of the benefits
32 provided under the plan contract.

33 (2) Silver level: A health care service plan contract in the silver
34 level shall provide a level of coverage that is actuarially equivalent
35 to 70 percent of the full actuarial value of the benefits provided
36 under the plan contract.

37 (3) Gold level: A health care service plan contract in the gold
38 level shall provide a level of coverage that is actuarially equivalent
39 to 80 percent of the full actuarial value of the benefits provided
40 under the plan contract.

1 (4) Platinum level: A health care service plan contract in the
2 platinum level shall provide a level of coverage that is actuarially
3 equivalent to 90 percent of the full actuarial value of the benefits
4 provided under the plan contract.

5 (b) Actuarial value for nongrandfathered small employer health
6 care service plan contracts shall be determined in accordance with
7 the following:

8 (1) Actuarial value shall not vary by more than plus or minus
9 2 percent.

10 (2) Actuarial value shall be determined on the basis of essential
11 health benefits as defined in Section 1367.005 and as provided to
12 a standard, nonelderly population. For this purpose, a standard
13 population shall not include those receiving coverage through the
14 Medi-Cal or Medicare programs.

15 (3) The department may use the actuarial value methodology
16 developed consistent with Section 1302(d) of PPACA.

17 (4) The actuarial value for pediatric dental benefits, whether
18 offered by a full service plan or a specialized plan, shall be
19 consistent with federal law and guidance applicable to the plan
20 type.

21 (5) The department, in consultation with the Department of
22 Insurance and the Exchange, shall consider whether to exercise
23 state-level flexibility with respect to the actuarial value calculator
24 in order to take into account the unique characteristics of the
25 California health care coverage market, including the prevalence
26 of health care service plans, total cost of care paid for by the plan,
27 price of care, patterns of service utilization, and relevant
28 demographic factors.

29 (6) Employer contributions toward health reimbursement
30 accounts and health savings accounts shall count toward the
31 actuarial value of the product in the manner specified in federal
32 rules and guidance.

33 (c) “PPACA” means the federal Patient Protection and
34 Affordable Care Act (Public Law 111-148), as amended by the
35 federal Health Care and Education Reconciliation Act of 2010
36 (Public Law 111-152), and any rules, regulations, or guidance
37 issued thereunder.

38 *SEC. 8. Section 10753.05 of the Insurance Code, as amended*
39 *by Chapter 1 of the First Extraordinary Session of the Statutes of*
40 *2013, is amended to read:*

1 10753.05. (a) No group or individual policy or contract or
2 certificate of group insurance or statement of group coverage
3 providing benefits to employees of small employers as defined in
4 this chapter shall be issued or delivered by a carrier subject to the
5 jurisdiction of the commissioner regardless of the situs of the
6 contract or master policyholder or of the domicile of the carrier
7 nor, except as otherwise provided in Sections 10270.91 and
8 10270.92, shall a carrier provide coverage subject to this chapter
9 until a copy of the form of the policy, contract, certificate, or
10 statement of coverage is filed with and approved by the
11 commissioner in accordance with Sections 10290 and 10291, and
12 the carrier has complied with the requirements of Section 10753.17.

13 (b) (1) On and after October 1, 2013, each carrier shall fairly
14 and affirmatively offer, market, and sell all of the carrier's health
15 benefit plans that are sold to, offered through, or sponsored by,
16 small employers or associations that include small employers for
17 plan years on or after January 1, 2014, to all small employers in
18 each geographic region in which the carrier makes coverage
19 available or provides benefits.

20 (2) A carrier that offers qualified health plans through the
21 Exchange shall be deemed to be in compliance with paragraph (1)
22 with respect to health benefit plans offered through the Exchange
23 in those geographic regions in which the carrier offers plans
24 through the Exchange.

25 (3) A carrier shall provide enrollment periods consistent with
26 PPACA and described in Section 155.725 of Title 45 of the Code
27 of Federal Regulations. Commencing January 1, 2014, a carrier
28 shall provide special enrollment periods consistent with the special
29 enrollment periods described in Section 10965.3, to the extent
30 permitted by PPACA, except for the triggering events identified
31 in paragraphs (d)(3) and (d)(6) of Section 155.420 of Title 45 of
32 the Code of Federal Regulations with respect to health benefit
33 plans offered through the Exchange.

34 (4) Nothing in this section shall be construed to require an
35 association, or a trust established and maintained by an association
36 to receive a master insurance policy issued by an admitted insurer
37 and to administer the benefits thereof solely for association
38 members, to offer, market or sell a benefit plan design to those
39 who are not members of the association. However, if the
40 association markets, offers or sells a benefit plan design to those

1 who are not members of the association it is subject to the
2 requirements of this section. This shall apply to an association that
3 otherwise meets the requirements of paragraph (8) formed by
4 merger of two or more associations after January 1, 1992, if the
5 predecessor organizations had been in active existence on January
6 1, 1992, and for at least five years prior to that date and met the
7 requirements of paragraph (5).

8 (5) A carrier which (A) effective January 1, 1992, and at least
9 20 years prior to that date, markets, offers, or sells benefit plan
10 designs only to all members of one association and (B) does not
11 market, offer or sell any other individual, selected group, or group
12 policy or contract providing medical, hospital and surgical benefits
13 shall not be required to market, offer, or sell to those who are not
14 members of the association. However, if the carrier markets, offers
15 or sells any benefit plan design or any other individual, selected
16 group, or group policy or contract providing medical, hospital and
17 surgical benefits to those who are not members of the association
18 it is subject to the requirements of this section.

19 (6) Each carrier that sells health benefit plans to members of
20 one association pursuant to paragraph (5) shall submit an annual
21 statement to the commissioner which states that the carrier is selling
22 health benefit plans pursuant to paragraph (5) and which, for the
23 one association, lists all the information required by paragraph (7).

24 (7) Each carrier that sells health benefit plans to members of
25 any association shall submit an annual statement to the
26 commissioner which lists each association to which the carrier
27 sells health benefit plans, the industry or profession which is served
28 by the association, the association's membership criteria, a list of
29 officers, the state in which the association is organized, and the
30 site of its principal office.

31 (8) For purposes of paragraphs (4) and (6), an association is a
32 nonprofit organization comprised of a group of individuals or
33 employers who associate based solely on participation in a
34 specified profession or industry, accepting for membership any
35 individual or small employer meeting its membership criteria,
36 which do not condition membership directly or indirectly on the
37 health or claims history of any person, which uses membership
38 dues solely for and in consideration of the membership and
39 membership benefits, except that the amount of the dues shall not
40 depend on whether the member applies for or purchases insurance

1 offered by the association, which is organized and maintained in
2 good faith for purposes unrelated to insurance, which has been in
3 active existence on January 1, 1992, and at least five years prior
4 to that date, which has a constitution and bylaws, or other
5 analogous governing documents which provide for election of the
6 governing board of the association by its members, which has
7 contracted with one or more carriers to offer one or more health
8 benefit plans to all individual members and small employer
9 members in this state. Health coverage through an association that
10 is not related to employment shall be considered individual
11 coverage pursuant to Section 144.102(c) of Title 45 of the Code
12 of Federal Regulations.

13 (c) On and after October 1, 2013, each carrier shall make
14 available to each small employer all health benefit plans that the
15 carrier offers or sells to small employers or to associations that
16 include small employers for plan years on or after January 1, 2014.
17 Notwithstanding subdivision (d) of Section 10753, for purposes
18 of this subdivision, companies that are affiliated companies or that
19 are eligible to file a consolidated income tax return shall be treated
20 as one carrier.

21 (d) Each carrier shall do all of the following:

22 (1) Prepare a brochure that summarizes all of its health benefit
23 plans and make this summary available to small employers, agents,
24 and brokers upon request. The summary shall include for each
25 plan information on benefits provided, a generic description of the
26 manner in which services are provided, such as how access to
27 providers is limited, benefit limitations, required copayments and
28 deductibles, an explanation of how creditable coverage is calculated
29 if a waiting period is imposed, and a telephone number that can
30 be called for more detailed benefit information. Carriers are
31 required to keep the information contained in the brochure accurate
32 and up to date, and, upon updating the brochure, send copies to
33 agents and brokers representing the carrier. Any entity that provides
34 administrative services only with regard to a health benefit plan
35 written or issued by another carrier shall not be required to prepare
36 a summary brochure which includes that benefit plan.

37 (2) For each health benefit plan, prepare a more detailed
38 evidence of coverage and make it available to small employers,
39 agents and brokers upon request. The evidence of coverage shall
40 contain all information that a prudent buyer would need to be aware

1 of in making selections of benefit plan designs. An entity that
2 provides administrative services only with regard to a health benefit
3 plan written or issued by another carrier shall not be required to
4 prepare an evidence of coverage for that health benefit plan.

5 (3) Provide copies of the current summary brochure to all agents
6 or brokers who represent the carrier and, upon updating the
7 brochure, send copies of the updated brochure to agents and brokers
8 representing the carrier for the purpose of selling health benefit
9 plans.

10 (4) Notwithstanding subdivision (c) of Section 10753, for
11 purposes of this subdivision, companies that are affiliated
12 companies or that are eligible to file a consolidated income tax
13 return shall be treated as one carrier.

14 (e) Every agent or broker representing one or more carriers for
15 the purpose of selling health benefit plans to small employers shall
16 do all of the following:

17 (1) When providing information on a health benefit plan to a
18 small employer but making no specific recommendations on
19 particular benefit plan designs:

20 (A) Advise the small employer of the carrier's obligation to sell
21 to any small employer any of the health benefit plans it offers to
22 small employers, consistent with PPACA, and provide them, upon
23 request, with the actual rates that would be charged to that
24 employer for a given health benefit plan.

25 (B) Notify the small employer that the agent or broker will
26 procure rate and benefit information for the small employer on
27 any health benefit plan offered by a carrier for whom the agent or
28 broker sells health benefit plans.

29 (C) Notify the small employer that, upon request, the agent or
30 broker will provide the small employer with the summary brochure
31 required in paragraph (1) of subdivision (d) for any benefit plan
32 design offered by a carrier whom the agent or broker represents.

33 (D) Notify the small employer of the availability of coverage
34 and the availability of tax credits for certain employers consistent
35 with PPACA and state law, including any rules, regulations, or
36 guidance issued in connection therewith.

37 (2) When recommending a particular benefit plan design or
38 designs, advise the small employer that, upon request, the agent
39 will provide the small employer with the brochure required by

1 paragraph (1) of subdivision (d) containing the benefit plan design
2 or designs being recommended by the agent or broker.

3 (3) Prior to filing an application for a small employer for a
4 particular health benefit plan:

5 (A) For each of the health benefit plans offered by the carrier
6 whose health benefit plan the agent or broker is presenting, provide
7 the small employer with the benefit summary required in paragraph
8 (1) of subdivision (d) and the premium for that particular employer.

9 (B) Notify the small employer that, upon request, the agent or
10 broker will provide the small employer with an evidence of
11 coverage brochure for each health benefit plan the carrier offers.

12 (C) Obtain a signed statement from the small employer
13 acknowledging that the small employer has received the disclosures
14 required by this paragraph and Section 10753.16.

15 (f) No carrier, agent, or broker shall induce or otherwise
16 encourage a small employer to separate or otherwise exclude an
17 eligible employee from a health benefit plan which, in the case of
18 an eligible employee meeting the definition in paragraph (1) of
19 subdivision (f) of Section 10753, is provided in connection with
20 the employee's employment or which, in the case of an eligible
21 employee as defined in paragraph (2) of subdivision (f) of Section
22 10753, is provided in connection with a guaranteed association.

23 (g) No carrier shall reject an application from a small employer
24 for a health benefit plan provided:

25 (1) The small employer as defined by subparagraph (A) of
26 paragraph (1) of subdivision (q) of Section 10753 offers health
27 benefits to 100 percent of its eligible employees as defined in
28 paragraph (1) of subdivision (f) of Section 10753. Employees who
29 waive coverage on the grounds that they have other group coverage
30 shall not be counted as eligible employees.

31 (2) The small employer agrees to make the required premium
32 payments.

33 (h) No carrier or agent or broker shall, directly or indirectly,
34 engage in the following activities:

35 (1) Encourage or direct small employers to refrain from filing
36 an application for coverage with a carrier because of the health
37 status, claims experience, industry, occupation, or geographic
38 location within the carrier's approved service area of the small
39 employer or the small employer's employees.

1 (2) Encourage or direct small employers to seek coverage from
2 another carrier because of the health status, claims experience,
3 industry, occupation, or geographic location within the carrier's
4 approved service area of the small employer or the small
5 employer's employees.

6 (3) Employ marketing practices or benefit designs that will have
7 the effect of discouraging the enrollment of individuals with
8 significant health needs or discriminate based on the individual's
9 race, color, national origin, present or predicted disability, age,
10 sex, gender identity, sexual orientation, expected length of life,
11 degree of medical dependency, quality of life, or other health
12 conditions.

13 This subdivision shall be enforced in the same manner as Section
14 790.03, including through Sections 790.035 and 790.05.

15 (i) No carrier shall, directly or indirectly, enter into any contract,
16 agreement, or arrangement with an agent or broker that provides
17 for or results in the compensation paid to an agent or broker for a
18 health benefit plan to be varied because of the health status, claims
19 experience, industry, occupation, or geographic location of the
20 small employer or the small employer's employees. This
21 subdivision shall not apply with respect to a compensation
22 arrangement that provides compensation to an agent or broker on
23 the basis of percentage of premium, provided that the percentage
24 shall not vary because of the health status, claims experience,
25 industry, occupation, or geographic area of the small employer.

26 (j) (1) A health benefit plan offered to a small employer, as
27 defined in Section 1304(b) of PPACA and in Section 10753, shall
28 not establish rules for eligibility, including continued eligibility,
29 of an individual, or dependent of an individual, to enroll under the
30 terms of the plan based on any of the following health status-related
31 factors:

32 (A) Health status.

33 (B) Medical condition, including physical and mental illnesses.

34 (C) Claims experience.

35 (D) Receipt of health care.

36 (E) Medical history.

37 (F) Genetic information.

38 (G) Evidence of insurability, including conditions arising out
39 of acts of domestic violence.

40 (H) Disability.

1 (I) Any other health status-related factor as determined by any
2 federal regulations, rules, or guidance issued pursuant to Section
3 2705 of the federal Public Health Service Act.

4 (2) Notwithstanding Section 10291.5, a carrier shall not require
5 an eligible employee or dependent to fill out a health assessment
6 or medical questionnaire prior to enrollment under a health benefit
7 plan. A carrier shall not acquire or request information that relates
8 to a health status-related factor from the applicant or his or her
9 dependent or any other source prior to enrollment of the individual.

10 (k) (1) A carrier shall consider as a single risk pool for rating
11 purposes in the small employer market the claims experience of
12 all insureds in all nongrandfathered small employer health benefit
13 plans offered by the carrier in this state, whether offered as health
14 care service plan contracts or health insurance policies, including
15 those insureds and enrollees who enroll in coverage through the
16 Exchange and insureds and enrollees covered by the carrier outside
17 of the Exchange.

18 (2) ~~Each~~ *At least each calendar year, and no more frequently*
19 *than each calendar quarter*, a carrier shall establish an index rate
20 for the small employer market in the state based on the total
21 combined claims costs for providing essential health benefits, as
22 defined pursuant to Section 1302 of PPACA and Section 10112.27,
23 within the single risk pool required under paragraph (1). The index
24 rate shall be adjusted on a marketwide basis based on the total
25 expected marketwide payments and charges under the risk
26 adjustment and reinsurance programs established for the state
27 pursuant to Sections 1343 and 1341 of PPACA. The premium rate
28 for all of the carrier's nongrandfathered health benefit plans shall
29 use the applicable index rate, as adjusted for total expected
30 marketwide payments and charges under the risk adjustment and
31 reinsurance programs established for the state pursuant to Sections
32 1343 and 1341 of PPACA, subject only to the adjustments
33 permitted under paragraph (3).

34 (3) A carrier may vary premium rates for a particular
35 nongrandfathered health benefit plan from its index rate based
36 only on the following actuarially justified plan-specific factors:

37 (A) The actuarial value and cost-sharing design of the health
38 benefit plan.

39 (B) The health benefit plan's provider network, delivery system
40 characteristics, and utilization management practices.

(C) The benefits provided under the health benefit plan that are in addition to the essential health benefits, as defined pursuant to Section 1302 of PPACA. These additional benefits shall be pooled with similar benefits within the single risk pool required under paragraph (1) and the claims experience from those benefits shall be utilized to determine rate variations for health benefit plans that offer those benefits in addition to essential health benefits.

(D) Administrative costs, excluding any user fees required by the Exchange.

(E) With respect to catastrophic plans, as described in subsection (e) of Section 1302 of PPACA, the expected impact of the specific eligibility categories for those plans.

(I) If a carrier enters into a contract, agreement, or other arrangement with a third-party administrator or other entity to provide administrative, marketing, or other services related to the offering of health benefit plans to small employers in this state, the third-party administrator shall be subject to this chapter.

(m) (1) Except as provided in paragraph (2), this section shall become inoperative if Section 2702 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-1), as added by Section 1201 of PPACA, is repealed, in which case, 12 months after the repeal, carriers subject to this section shall instead be governed by Section 10705 to the extent permitted by federal law, and all references in this chapter to this section shall instead refer to Section 10705, except for purposes of paragraph (2).

(2) Paragraph (3) of subdivision (b) of this section shall remain operative as it relates to health benefit plans offered through the Exchange.

~~SEC. 6.~~

~~SEC. 9.~~ Section 10112.28 is added to the Insurance Code, to read:

10112.28. (a) *This section shall apply to nongrandfathered individual and group health insurance policies that provide coverage for essential health benefits, as defined in Section 10112.27, and that are issued, amended, or renewed on or after January 1, 2015.*

(b) (1) For nongrandfathered ~~products~~ health insurance policies in the individual or small group markets, a health insurance policy, except a specialized health insurance policy, that is issued, amended, or renewed on or after January 1, ~~2014~~, 2015, shall

1 provide for a limit on annual out-of-pocket expenses for all covered
2 benefits that meet the definition of essential health benefits in
3 Section 10112.27, *including out-of-network emergency care*.

4 ~~(A) In the first policy year commencing on or after January 1,~~
5 ~~2014, to the extent allowed by federal law, for nongrandfathered~~
6 ~~health insurance policies in the individual and small group markets,~~
7 ~~when an insurer uses a separate service provider to administer the~~
8 ~~pediatric oral care benefits required by Section 10112.27, the limit~~
9 ~~on annual out-of-pocket expenses shall be satisfied if both of the~~
10 ~~following conditions are met:~~

11 ~~(i) With respect to all essential health benefits except for the~~
12 ~~pediatric oral care benefit, the insurer complies with the~~
13 ~~out-of-pocket maximum requirements in Section 1302(c)(1) of~~
14 ~~PPACA and any federal rules, regulations, and guidance~~
15 ~~implementing that section.~~

16 ~~(ii) The separate out-of-pocket maximum for pediatric oral care~~
17 ~~benefits does not exceed the out-of-pocket maximum requirements~~
18 ~~for pediatric dental benefits established for stand-alone dental~~
19 ~~policies by the California Health Benefit Exchange.~~

20 ~~(B) The insurer shall not apply a separate out-of-pocket~~
21 ~~maximum to mental health or substance use disorder benefits.~~

22 (2) For nongrandfathered ~~products~~ *health insurance policies* in
23 the large group market, a health insurance policy, except a
24 specialized health insurance policy, that is issued, amended, or
25 renewed on or after January 1, 2014, 2015, shall provide for a limit
26 on annual out-of-pocket expenses for covered benefits, including
27 out-of-network emergency care. This limit shall apply *only* to
28 essential health benefits, as defined in Section 10112.27, that are
29 covered under the policy to the extent that this provision does not
30 conflict with federal law or guidance on out-of-pocket maximums
31 for nongrandfathered ~~products~~ *health insurance policies* in the
32 large group market. ~~For large group products for the first plan year~~
33 ~~commencing on or after January 1, 2014, the requirement that a~~
34 ~~product provide for a limit on annual out-of-pocket expenses shall~~
35 ~~be satisfied if both of the following apply:~~

36 ~~(A) The product complies with the requirements of this~~
37 ~~paragraph with respect to basic health care services, as defined in~~
38 ~~Sections 10112.27, 10144.05, 10144.51, and any requirements of~~
39 ~~the Paul Wellstone and Pete Domenici Mental Health Parity and~~
40 ~~Addiction Equity Act of 2008 (Public Law 110-343).~~

1 ~~(B) To the extent the product includes an out-of-pocket~~
2 ~~maximum on coverage other than the coverage described in~~
3 ~~subparagraph (A), that out-of-pocket maximum also does not~~
4 ~~exceed the limit established pursuant to this paragraph.~~

5 ~~(b) The limit described in subdivision (a) shall apply to any~~
6 ~~copayment, coinsurance, deductible, incentive payment and any~~
7 ~~other form of cost sharing for all covered benefits, including~~
8 ~~nonformulary prescription drugs that are authorized as medically~~
9 ~~necessary.~~

10 (c) (1) The limit described in subdivision ~~(a)~~ (b) shall not
11 exceed the limit described in Section 1302(c) of PPACA and any
12 subsequent rules, regulations, or guidance issued under that section.

13 (2) *The limit described in subdivision (b) shall result in a total*
14 *maximum out-of-pocket limit for all covered essential health*
15 *benefits that shall equal the dollar amounts in effect under Section*
16 *223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 with the*
17 *dollar amounts adjusted as specified in Section 1302(c)(1)(B) of*
18 *PPACA.*

19 (d) Nothing in this section shall be construed to affect the
20 reduction in cost sharing for eligible ~~enrollees insureds~~ described
21 in Section 1402 of PPACA and any subsequent rules, regulations,
22 or guidance issued under that section.

23 (e) ~~For policy years beginning on or after January 1, 2015, if~~ *If*
24 ~~an essential health benefit is offered or provided by a specialized~~
25 ~~health insurance policy, the total annual out-of-pocket maximum~~
26 ~~for all covered essential benefits shall not exceed the limit in this~~
27 ~~section subdivision (b).~~ *This section shall not apply to a specialized*
28 *health insurance policy that does not offer an essential health*
29 *benefit as defined in Section 10112.28.*

30 (f) *The maximum out-of-pocket limit shall apply to any*
31 *copayment, coinsurance, deductible, and any other form of cost*
32 *sharing for all covered benefits that meet the definition of essential*
33 *health benefits, as defined in Section 10112.28.*

34 ~~(f)~~
35 (g) For nongrandfathered health insurance policies in the group
36 market, “policy year” has the meaning set forth in Section 144.103
37 of Title 45 of the Code of Federal Regulations. For
38 nongrandfathered health insurance policies sold in the individual
39 market, “policy year” means the calendar year.

40 ~~(g)~~

1 (h) “PPACA” means the federal Patient Protection and
2 Affordable Care Act (Public Law 111-148), as amended by the
3 federal Health Care and Education Reconciliation Act of 2010
4 (Public Law 111-152), and any rules, regulations, or guidance
5 issued thereunder.

6 *SEC. 10. Section 10112.285 is added to the Insurance Code,*
7 *to read:*

8 *10112.285. (a) This section shall apply to nongrandfathered*
9 *individual and group health insurance policies that provide*
10 *coverage for essential health benefits defined in Section 10112.27*
11 *and that are issued, amended, or renewed for the 2014 policy year.*

12 *(b) (1) For nongrandfathered health insurance policies in the*
13 *individual market, and to the extent allowed by federal law,*
14 *regulations, and guidance, a health insurance policy, except a*
15 *specialized health insurance policy, shall provide for a limit on*
16 *annual out-of-pocket expenses for all covered benefits that meet*
17 *the definition of essential health benefits, as defined in Section*
18 *10112.27, including out-of-network emergency care. The total*
19 *out-of-pocket maximum shall not exceed six thousand three*
20 *hundred fifty dollars (\$6,350) for individual coverage and twelve*
21 *thousand seven hundred dollars (\$12,700) for family coverage.*

22 *(2) For nongrandfathered specialized health insurance policies*
23 *in the individual market that provide the pediatric oral care benefit*
24 *meeting the definition in Section 1302(b)(1)(j) of PPACA, the*
25 *out-of-pocket maximum for the pediatric oral care benefit shall*
26 *not exceed one thousand dollars (\$1,000) for one child and two*
27 *thousand dollars (\$2,000) for more than one child.*

28 *(3) A health insurance policy shall not apply a separate*
29 *out-of-pocket maximum to mental health or substance use disorder*
30 *benefits.*

31 *(c) For nongrandfathered health insurance policies in the small*
32 *group markets, and to the extent allowed by federal law,*
33 *regulations, and guidance, a health insurance policy, except a*
34 *specialized health insurance policy, shall provide for a limit on*
35 *annual out-of-pocket expenses for all covered benefits that meet*
36 *the definition of essential health benefits, as defined in Section*
37 *10112.27, including out-of-network emergency care, as follows:*

38 *(1) With respect to all essential health benefits, except for the*
39 *pediatric oral care benefit, the total out-of-pocket maximum shall*
40 *not exceed six thousand three hundred fifty dollars (\$6,350) for*

1 individual coverage and twelve thousand seven hundred dollars
2 (\$12,700) for family coverage. For small group health insurance
3 policies the total out-of-pocket maximum limit in this paragraph
4 may be split between prescription drug services and all other
5 essential health benefits.

6 (2) The separate out-of-pocket maximum for pediatric oral care
7 benefits meeting the definition in Section 1302(b)(1) of PPACA
8 shall not exceed one thousand dollars (\$1,000) for one child and
9 two thousand dollars (\$2,000) for more than one child.

10 (3) A health insurance policy shall not apply a separate
11 out-of-pocket maximum to mental health or substance use disorder
12 benefits.

13 (d) For nongrandfathered health insurance policies in the large
14 group market, a health insurance policy, except a specialized
15 health insurance policy, shall provide for a limit on annual
16 out-of-pocket expenses for covered benefits, including
17 out-of-network emergency care. This limit shall apply only to
18 essential health benefits, as defined in Section 10112.27, that are
19 covered under the policy. This limit shall be as follows:

20 (1) The total out-of-pocket maximum shall not exceed six
21 thousand three hundred fifty dollars (\$6,350) for individual
22 coverage or twelve thousand seven hundred dollars (\$12,700) for
23 family coverage with respect to basic health care services
24 described in Section 10112.27, and services, except for prescription
25 drugs, required under Sections 10144.5 and 10144.51.

26 (2) To the extent the policy includes an out-of-pocket maximum
27 on coverage other than the coverage described in paragraph (1),
28 that out-of-pocket maximum shall not exceed six thousand three
29 hundred fifty dollars (\$6,350) for individual coverage or twelve
30 thousand seven hundred dollars (\$12,700) for family coverage.

31 (3) An insured in a large group policy shall not be subject to
32 more than two limits on annual out-of-pocket expenses for covered
33 benefits that meet the definition of essential health benefits.

34 (4) A health insurance policy shall not apply a separate
35 out-of-pocket maximum to mental health or substance use disorder
36 benefits.

37 (5) This subdivision shall apply only to the extent that it does
38 not conflict with federal law or guidance on out-of-pocket
39 maximums for nongrandfathered policies in the large group
40 market.

1 (e) Nothing in this section shall be construed to affect the
2 reduction in cost sharing for eligible insureds described in Section
3 1402 of PPACA, and any subsequent rules, regulations, or
4 guidance issued under that section.

5 (f) The limits described in this section shall apply to any
6 copayment, coinsurance, deductible, and any other form of cost
7 sharing for all covered services that meet the definition of essential
8 health benefits.

9 (g) For nongrandfathered health insurance policies in the group
10 market, “policy year” has the meaning set forth in Section 144.103
11 of Title 45 of the Code of Federal Regulations. For
12 nongrandfathered health insurance policies sold in the individual
13 market, “policy year” means the calendar year.

14 (h) “PPACA” means the federal Patient Protection and
15 Affordable Care Act (Public Law 111-148), as amended by the
16 federal Health Care and Education Reconciliation Act of 2010
17 (Public Law 111-152), and any rules, regulations, or guidance
18 issued thereunder.

19 (i) This section shall remain in effect only until January 1, 2016,
20 and as of that date is repealed, unless a later enacted statute, that
21 is enacted before January 1, 2016, deletes or extends that date.

22 ~~SEC. 7.~~

23 SEC. 11. Section 10112.29 is added to the Insurance Code, to
24 read:

25 10112.29. (a) (1) For a small employer health insurance policy
26 offered, sold, or renewed on or after January 1, 2014, the deductible
27 under the policy shall not exceed:

28 (A) Two thousand dollars (\$2,000) in the case of a policy
29 covering a single individual.

30 (B) Four thousand dollars (\$4,000) in the case of any other
31 policy.

32 (2) The dollar amounts in this section shall be indexed consistent
33 with Section 1302(c)(2) of PPACA and any federal rules or
34 guidance pursuant to that section.

35 (3) The limitation in this subdivision shall be applied in a
36 manner that does not affect the actuarial value of any small
37 employer health insurance policy.

38 (4) For small group products at the bronze level of coverage,
39 as defined in Section 10112.295, the department may permit
40 insurers to offer a higher deductible in order to meet the actuarial

1 value requirement of the bronze level. In making this
2 determination, the department shall consider affordability of cost
3 sharing for insureds and shall also consider whether insureds may
4 be deterred from seeking appropriate care because of higher cost
5 sharing.

6 (b) Nothing in this section shall be construed to allow a policy
7 to have a deductible that applies to preventive services as defined
8 in PPACA.

9 (c) *This section shall not apply to multiple employer welfare*
10 *arrangements regulated pursuant to Article 4.7 (commencing with*
11 *Section 742.20) of Chapter 1 of Part 2 of Division 1 that provide*
12 *health care benefits to their members and that comply with small*
13 *group health reforms unless otherwise required by federal law or*
14 *guidance.*

15 (e)

16 (d) “PPACA” means the federal Patient Protection and
17 Affordable Care Act (Public Law 111-148), as amended by the
18 federal Health Care and Education Reconciliation Act of 2010
19 (Public Law 111-152), and any rules, regulations, or guidance
20 issued thereunder.

21 ~~SEC. 8.~~

22 *SEC. 12.* Section 10112.295 is added to the Insurance Code,
23 to read:

24 10112.295. (a) Levels of coverage for the nongrandfathered
25 individual market are defined as follows:

26 (1) Bronze level: A health insurance policy in the bronze level
27 shall provide a level of coverage that is actuarially equivalent to
28 60 percent of the full actuarial value of the benefits provided under
29 the policy.

30 (2) Silver level: A health insurance policy in the silver level
31 shall provide a level of coverage that is actuarially equivalent to
32 70 percent of the full actuarial value of the benefits provided under
33 the policy.

34 (3) Gold level: A health insurance policy in the gold level shall
35 provide a level of coverage that is actuarially equivalent to 80
36 percent of the full actuarial value of the benefits provided under
37 the policy.

38 (4) Platinum level: A health insurance policy in the platinum
39 level shall provide a level of coverage that is actuarially equivalent

1 to 90 percent of the full actuarial value of the benefits provided
2 under the policy.

3 (b) Actuarial value for nongrandfathered individual health
4 insurance policies shall be determined in accordance with the
5 following:

6 (1) Actuarial value shall not vary by more than plus or minus
7 2 percent.

8 (2) Actuarial value shall be determined on the basis of essential
9 health benefits as defined in Section 10112.27 and as provided to
10 a standard, nonelderly population. For this purpose, a standard
11 population shall not include those receiving coverage through the
12 Medi-Cal or Medicare programs.

13 (3) The department may use the actuarial value methodology
14 developed consistent with Section 1302(d) of PPACA.

15 (4) The actuarial value for pediatric dental benefits, whether
16 offered by a major medical policy or a specialized health insurance
17 policy, shall be consistent with federal law and guidance applicable
18 to the policy type.

19 (5) The department, in consultation with the Department of
20 Managed Health Care and the Exchange, shall consider whether
21 to exercise state-level flexibility with respect to the actuarial value
22 calculator in order to take into account the unique characteristics
23 of the California health care coverage market, including the
24 prevalence of health insurance policies, total cost of care paid for
25 by the health insurer, price of care, patterns of service utilization,
26 and relevant demographic factors.

27 (c) (1) A catastrophic policy is a health insurance policy that
28 provides no benefits for any plan year until the insured has incurred
29 cost-sharing expenses in an amount equal to the annual limit on
30 out-of-pocket costs as specified in Section 10112.28 except that
31 it shall provide coverage for at least three primary care visits. A
32 carrier that is not participating in the Exchange shall not offer,
33 market, or sell a catastrophic plan in the individual market.

34 (2) A catastrophic policy may be offered only in the individual
35 market and only if consistent with this paragraph. Catastrophic
36 policies may be offered only if either of the following apply:

37 (A) The individual purchasing the policy has not yet attained
38 30 years of age before the beginning of the plan year.

39 (B) The individual has a certificate of exemption from Section
40 5000(A) of the Internal Revenue Code because the individual is

1 not offered affordable coverage or because the individual faces
2 hardship.

3 *(d) This section shall apply to a policy of health insurance, as*
4 *defined in subdivision (b) of Section 106, that covers any essential*
5 *health benefit as defined in Section 10112.27. This section shall*
6 *not apply to a specialized health insurance policy that does not*
7 *cover any of the essential health benefits.*

8 ~~(d)~~

9 *(e) “PPACA” means the federal Patient Protection and*
10 *Affordable Care Act (Public Law 111-148), as amended by the*
11 *federal Health Care and Education Reconciliation Act of 2010*
12 *(Public Law 111-152), and any rules, regulations, or guidance*
13 *issued thereunder.*

14 ~~SEC. 9.~~

15 *SEC. 13.* Section 10112.297 is added to the Insurance Code,
16 to read:

17 10112.297. (a) Levels of coverage for the nongrandfathered
18 small group market are defined as follows:

19 (1) Bronze level: A health insurance policy in the bronze level
20 shall provide a level of coverage that is actuarially equivalent to
21 60 percent of the full actuarial value of the benefits provided under
22 the policy.

23 (2) Silver level: A health insurance policy in the silver level
24 shall provide a level of coverage that is actuarially equivalent to
25 70 percent of the full actuarial value of the benefits provided under
26 the policy.

27 (3) Gold level: A health insurance policy in the gold level shall
28 provide a level of coverage that is actuarially equivalent to 80
29 percent of the full actuarial value of the benefits provided under
30 the policy.

31 (4) Platinum level: A health insurance policy in the platinum
32 level shall provide a level of coverage that is actuarially equivalent
33 to 90 percent of the full actuarial value of the benefits provided
34 under the policy.

35 (b) Actuarial value for nongrandfathered small employer health
36 insurance policies shall be determined in accordance with the
37 following:

38 (1) Actuarial value shall not vary by more than plus or minus
39 2 percent.

(2) Actuarial value shall be determined on the basis of essential health benefits as defined in paragraph (1) of subdivision (a) of Section 10112.27 and as provided to a standard, nonelderly population. For this purpose, a standard population shall not include those receiving coverage through the Medi-Cal or Medicare programs.

(3) The department may use the actuarial value methodology developed consistent with Section 1302(d) of PPACA.

(4) The actuarial value for pediatric dental benefits, whether offered by a major medical policy or a specialized health insurance policy, shall be consistent with federal law and guidance applicable to the policy type.

(5) The department, in consultation with the Department of Managed Health Care and the Exchange, shall consider whether to exercise state-level flexibility with respect to the actuarial value calculator in order to take into account the unique characteristics of the California health care coverage market, including the prevalence of health insurance policies, total cost of care paid for by the health insurer, price of care, patterns of service utilization, and relevant demographic factors.

(6) Employer contributions toward health reimbursement accounts and health savings accounts shall count toward the actuarial value of the product in the manner specified in federal rules and guidance.

(c) “PPACA” means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

~~SEC. 10.~~

SEC. 14. Section 10112.7 is added to the Insurance Code, to read:

10112.7. (a) A group or individual health insurance policy issued, amended, or renewed on or after January 1, 2014, that provides or covers any benefits with respect to services in an emergency department of a hospital shall cover emergency services as follows:

(1) Without the need for any prior authorization determination.

(2) Whether the health care provider furnishing the services is a participating provider with respect to those services.

1 (3) In a manner so that, if the services are provided to an insured:

2 (A) By a nonparticipating health care provider with or without
3 prior authorization; or

4 (B) (i) The services will be provided without imposing any
5 requirement under the policy for prior authorization of services or
6 any limitation on coverage where the provider of services does
7 not have a contractual relationship with the insurer for the
8 providing of services that is more restrictive than the requirements
9 or limitations that apply to emergency department services received
10 from providers who do have such a contractual relationship with
11 the insurer; and

12 (ii) If the services are provided to an insured out-of-network,
13 the cost-sharing requirement, expressed as a copayment amount
14 or coinsurance rate, is the same requirement that would apply if
15 the services were provided in-network.

16 (b) For the purposes of this section, the term “emergency
17 services” means, with respect to an emergency medical condition:

18 (1) A medical screening examination that is within the capability
19 of the emergency department of a hospital, including ancillary
20 services routinely available to the emergency department to
21 evaluate that emergency medical condition.

22 (2) Within the capabilities of the staff and facilities available at
23 the hospital, further medical examination and treatment as are
24 required under Section 1867(e)(3) of the federal Social Security
25 Act (42 U.S.C. 1395dd(e)(3)) to stabilize the patient.

26 ~~SEC. 11.~~

27 *SEC. 15.* No reimbursement is required by this act pursuant
28 to Section 6 of Article XIII B of the California Constitution because
29 the only costs that may be incurred by a local agency or school
30 district will be incurred because this act creates a new crime or
31 infraction, eliminates a crime or infraction, or changes the penalty
32 for a crime or infraction, within the meaning of Section 17556 of
33 the Government Code, or changes the definition of a crime within
34 the meaning of Section 6 of Article XIII B of the California
35 Constitution.